Evidence Required In Support of a Claim for Work-Related Skin Diease

U.S. Department of Labor
Employment Standards Administration
Office of Workers Compensation Programs

IF YOU ARE FILING A CLAIM FOR A SKIN CONDITION, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be sumitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✔
1. Give a detailed description of employment factors you believe responsible for your condition, to include: a. Specific type of exposure. b. Frequency and duration of exposure. c. Protective equipment used to guard against exposure.	
2. Describe any exposure to skin irritants outside the work environment, including the type, duration and frequency of exposure.	
3. Describe any previous skin conditions from the time they began through the present.	
4. Provide treatment records from any physicians who have provided treatment for any skin conditions.	
5. Attach or forward a medical report from your current physician to include: a. History of exposure. b. Findings. c. Diagnosis. d. Details of treatment. e. Explanation of the relationship between the findings and exposure history listed in Item no. 1 above. f. Discussion of temporary vs. permanent effect from work exposure. g. Work restrictions caused by the condition.	

FROM EMPLOYING AGENCY	✔
6. Review and comment on the employee's statements provided in response to questions 1-5. Comment on the exposure claimed, providing any available information about the trade name and/or chemical content of the suspected irritants.	
7. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's a. SF-171, Application for Employment. b. Position description with physical requirements. c. Pertinent dispensary records. d. Copies of all physical examinations on file. e. Most recent SF-50, Notification of Personnel Action.	

Figure 810-32. Skin Disease Check List.

Evidence Required in Support of A Claim for Asbestos-Related Illness

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

If you are filing a claim based on exposure to asbestos, use this checklist to identify the information needed from you and your employing agency. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✔
1. List your employment history by employer, job title, and inclusive dates. Include non-Federal employment and military service **(see attached questionnaire.)**	
2. For each job title, describe the work you performed, the type of asbestos material used, locations where exposure occurred, period of exposure, number of hours per day and days per week exposed, and the types and frequency of safety precautions (mask, respirator, etc.) used **(see attached questionnaire).**	
3. Describe any exposure you have had to other toxic substances. If none, state "None".	
4. Describe any breathing or lung problems you have had in the past and treatment received **(see attached questionnaire).**	
5. Give your smoking history to include amount per day, and years (dates) you have smoked **(see attached questionnaire).**	
6. Submit a report from your physician, including chest x-ray report, history, physical findings, diagnosis, opinion as to the relationship of the condition to employment, and course of treatment.	
7. Give the date you first consulted a physician regarding respiratory or asbestos-related disease.	
8. Submit reports of examination, treatment or hospitalization for any previous similar condition or pulmonary problem.	

FROM EMPLOYING AGENCY	✔
9. Review and comment on the accuracy of the employee's description of work performed and exposure to asbestos and other substances.	
10. Provide exposure data, including air sample surveys or statements of the type of asbestos exposure, frequency, degree and duration for each job held. Air sample results should be reported in units of fiber/cc time weighted average. Also report concentrations of other pollutants and chemicals **(see attached questionnaire).**	
11. Give the date employee was last exposed to asbestos at work. If the employee was removed from exposure, give the circumstances.	
12. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements for last job held. c. Job sheet and employment record. d. Pertinent dispensary records. e. Most recent SF-50, Notification of Personnel Action. f. Laboratory test results and chest x-ray reports on file.	
13. Describe safety regulations and protective devices in use by employee, with period and frequency of use.	

Figure 810-33. Asbestos-Related Illness Check List.

PART A TO BE COMPLETED BY CLAIMANT

In order to determine if you are eligible for benefits, please provide the following information using your best estimates. If you run out of space, u a separate piece of paper and attach it to this form. Submit the form to your current (or last) employing agency. If the facility is no longer active, submit the statement to OWCP.

I. Employment History: Please include all employers, both Federal and non-Federal, your job titles, the work you performed, and the period you held each job. (Include military service).

Employer (Agency)	Job Title	Work Performed	Period	Fed. Civil Service? (Yes/N
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

II. Exposure History: Please describe all exposure to asbestos and other toxic materials in your employment. Include period of employment, type of exposure, number of hours exposed per workday and description of safety precautions used while working.

a. Asbestos: For "type of exposure" indicate whether exposure was heavy, medium or light:

Heavy - Visible airborne asbestos particles were evident.

Medium - Asbestos dust was visible on floors and work surfaces.

Light - No dust visible, but asbestos was in use.

Period	Type of Exposure (H, M, L)	Exposure Hrs/Day	Safety Precautions Used
1.			
2.			
3.			
4.			
5.			

b. Toxic Chemicals/Dust

Period	Material Exposed to:	Exposure Hrs/Day	Safety Precautions Used
1.			
2.			
3.			
4.			
5.			

(PLEASE CONTINUE ON REVERSE SIDE)

Figure 810-34 CA-35c with Instructions

III. Medical History: Describe your medical history and include any treatment for heart, lung and other major health problems.

Have you ever had:	Yes	No	If Yes, explain	Dates
1. Heart Problems?				
2. Lung Problems?				
3. Other Major Problems?				

IV. Smoking History: Describe your smoking history, including dates you smoked, amount of material smoked per day, and type of material smoked.

Have you ever smoked:	Yes	No	If Yes, amount	No. of years	Date stopped	Dates
1. Cigarettes?						
2. Pipe?						
3. Cigars?						

PART B TO BE COMPLETED BY EMPLOYING AGENCY

Using the categories shown below, please complete the chart at the bottom of the page with reference to each Federal job held by this employee.

a. Nature of Exposure:

Primary - Normal duties required actual manipulation of asbestos and/or asbestos-related products and generated dust.

Secondary - Normal duties regularly involved work alongside others primarily exposed or in confined spaces.

Intermittent - Normal duties irregularly involved entry into locations where asbestos and/or asbestos products were manipulated.

Environmental - Normal duties were performed at a location where asbestos was used but the individual had no normal exposure in excess of ambient levels.

b. Degree of Exposure:

Heavy - Asbestos dust was usually visible in the air.

Medium - Asbestos dust was generally visible on work surfaces but did not cloud the air.

Light - Asbestos was used in work area but was generally not visible (although detectable).

Ambient - Asbestos levels did not exceed normal levels in the air outside of work spaces.

c. Frequency of Exposure: Hours per day.

Job Title	Period		Asbestos Exposure			Other Chemical or Dust Exposure				
	From	To	Nature	Degree	Frequency	Material	Nature	Degree	Frequency	Fiber/cc
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										

☆U.S. GPO: 1988—202-081

Figure 810-34 Continued. CA-35c with Instructions.

FEDERAL INJURY COMPENSATION

Evidence Required In Support of a Claim for Work-Related Coronary/Vascular Condition

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

IF YOU ARE FILING A CLAIM FOR CORONARY OR VASCULAR CONDITIONS (for example: heart attack, stroke, hypertension). THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓
1. Give a detailed description of the factors of your employment you believe responsible for your condition. Identify dates, periods, events, people involved, etc.	
2. If you are claiming compensation for a heart attack or stroke, provide a specific account of your activities on and off duty for one week prior to the attack, with emphasis on the twenty-four hours immediately preceding the attack.	
3. If you have a prior history of heart problems, provide a description of your condition and copies of medical records of treatment.	
4. Give your smoking history to include amounts and years (dates) you smoked.	
5. Provide a medical report from your physician which includes: a. Dates of examination and treatment. b. History given by you. c. Family history and other risk factors. d. Detailed description of findings. e. Copies of all diagnostic test results. f. Diagnosis. g. The clinical course of treatment followed. h. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may now have and the factors of employment identified in item no. 1 above.	

FROM EMPLOYING AGENCY	✓
6. Review and comment on the employee's statements in response to questions 1-5.	
7. Describe in detail the duties of the employee and the manner in which the duties were performed. If the work was different or more stressful than that performed by other employees, this should be explained.	
8. Document any personnel actions described in the employee's statement, such as changes in assignment, grievances filed by the employee, and other adverse personnel actions.	
9. Give the number of hours worked per day, days per week and the extent of overtime duty worked.	
10. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
11. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Preemployment medical examination. d. All other pertienent medical reports available. e. Most recent SF-50, Notification of Personnel Action.	

Figure 810-35. Coronary/Vascular Condition Check-List.

Evidence Required in Support of a Claim for Work-Related Psychiatric Illness

U.S. Department of Labor
Employment Standards Administration
Office of Workers Compensation Programs

IF YOU ARE FILING A CLAIM FOR A PSYCHIATRIC CONDITION, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✔
1. Give a detailed chronological description of particular employment factors which you believe caused your condition. Please identify dates, periods, events, people involved, etc.	
2. Describe the progress and development of the work-related condition from its beginning.	
3. Have you previously suffered from this or a similar condition? If so, give details of symptoms, disability and treatment records from all physicians and hospitals where you were treated.	
4. Give a brief description of your personal activities, hobbies, and any other employment.	
5. Describe changes or other sources of stress in your personal life occurring in the same time frame.	
6. Attach or forward a medical report as described on the reverse.	

FROM EMPLOYING AGENCY	✔
7. Review and comment on the employee's statements provided in response to questions 1-5. Submit statements from witnesses, if appropriate.	
8. Provide a detailed statement describing the duties of the employee and the manner in which the duties were performed. If the work was different or more stressful than that performed by other employees, this should be explained.	
9. Document any personnel actions described in the employee's statement, such as changes in assignment, grievances filed by the employee, and other adverse personnel actions.	
10. Give the number of hours worked per day, days per week and the extent of overtime duty worked.	
11. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
12. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Preemployment medical examination. d. All other pertinent medical reports available. e. Most recent SF-50, Notification of Personnel Action.	

Figure 810-36. Work Related Psychiatric Check-List.

1

Evidence Required in Support of A Claim for Work-Related Carpal Tunnel Syndrome

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

If you are claiming that your carpal tunnel or wrist problems are due to your job, use this checklist to identify the specific information needed from you and your employing agency to make a decision on the claim. All of the following information should be submitted with Form CA-2. Please return the checklist with statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓	FROM EMPLOYING AGENCY
1. Prepare a statement giving the following information:		1. Review the employee's statement, giving the following information:
a. Provide an outline of your work history, including non-Federal employment and military service. For each job held, give your job title, agency/company name, and dates (period) of employment.		a. Comment on the accuracy of the employee's statement describing Federal job duties involving use of hand/wrist.
b. For each job title, describe duties which required exertion with or repeated movement of the wrist or hand. Describe nature and frequency of motions required, and average number of hours a day/week you did such work.		b. Provide a day-to-day listing of leave and leave without pay used by the employee due to carpal tunnel/wrist problems.
c. Describe hobbies, physical fitness or other activities outside of work which also involved exertion or repeated motions of wrist/hand. State the nature of each such activity, years involved in each, and how many hours a week you engaged in such.		c. Give date employee entered on duty in job requiring above duties. Also give the effective date(s) and description(s) of any changes in work assignments due to employee's condition and indicate whether duty changes resulted in changes in pay.
d. If you have ever had an injury to the hand/arm/wrist, or been diagnosed as having gout, arthritis, hypothyroidism, diabetes, a tumor, or deformity of the hand/wrist, from/since birth, describe the injury or condition, and state when injury occurred or condition was found.		2. Send us copies of employee's:
e. Give a brief chronological history of your hand/wrist problem. State which hand(s) are affected, when you first experienced problems, nature of the problems and changes over time to present, and dates and nature of medical care obtained.		a. SF-171, Application for Employment; b. Position description with physical requirements for last job held; c. All available medical records, including report of pre-employment examination; d. SF-50s or equivalent documents for changes in assignment/pay due to condition.
2. Ask all doctors who treated you to send us a copy of reports or notes describing the condition, testing, and treatment given.		

3. Ask the doctor currently treating your condition to provide a detailed current medical report to include the following specifics:

a. Dates of examinations;

b. Complete medical history of condition;

c. Medical diagnosis of condition;

d. Findings and test results, specifically including: results of Phalen's and Tinel's Sign tests; physical findings concerning sensation over palmar aspect of first three and one-half digits, and dorsal aspect of end joints of same digits, and any atrophy of the Thenar Eminence; results of nerve conduction velocity, and electromyographic testing;

e. Treatment to date and prognosis;

f. Reasoned opinion explaining any causal relationship between the condition and your Federal civilian job.

It is MOST IMPORTANT that the doctor provide opinion as to the likely nature of the physical effects attributable to specified duties of your Federal job, and explain the medical reasoning which supports the opinion as to cause.

Figure 810-37. Sample Carpal Tunnel Syndrome Check-List.

Evidence Required in Support of a Claim for Occupational Disease

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✔
1. Give a detailed description of factors of employment believed responsible for condition. Be specific as to the duration and nature of the factors: for instance weights carried, distances walked, chemicals used, or other relevant job factors.	
2. Give the history of the condition from first awareness of the problem. Include description of all home treatment and professional care as well as symptoms.	
3. Describe any prior similar problem, with dates of onset, history, medical care received, and copies of the medical records of your treatment.	
4. Attach or forward a medical report from your physician to include the following items: a. Dates of examination and treatment. b. History given by you. c. Detailed description of findings. d. Results of all diagnostic tests. e. Diagnosis. f. The clinical course of treatment followed. g. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may now have and the factors of employment identified in item no. 1 above.	

FROM EMPLOYING AGENCY	✔
5. Review and comment on employee's statement provided in response to item no. 1.	
6. If employee's job differs from official description, describe exactly his/her duties.	
7. Give a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Pertinent dispensary records. d. Most recent SF-50, Notification of Personnel Action.	

Figure 810-38. Occupational Disease Check-List.

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Controversion of FECA Claim - Orville G. Flye, DOI-Unknown

TO: Office of Workers' Compensation Programs
Street Address
City, State, Zip Code

Dear Claims Examiner:

Reference is made to the attached Form CA-2 submitted by Mr. Orville G. Flye, in which he is claiming compensation for his asbestosis condition. He alleges that his condition resulted from exposure to asbestos while he was employed as a Steamfitter at Brookley Field in 1946 and 1947.

As you are aware, Brookley Air Force Base was closed in the late 1960s. Because of this we have no personal knowledge what his duties, working conditions or who his supervisors were at that time. We have not completed the reverse side of Form CA-2.

We have, however, obtained his official personnel folder and medical records from the National Records Center. Based on our review of the documents contained therein, the following information concerns his Federal employment:

a. He was initially employed at Brookley Field from 8 April 1942 through 15 July 1944 when he was placed on military furlough. During this period, he worked as a General Mechanic Helper, Junior Machinist, and Machinist with no exposure indicated.

b. On 9 July 1946, he was reemployed following his military service and was terminated (displacement) on 15 May 1947. During this period, he did work as a Steamfitter, Grade 14, Step 4. His starting and ending salaries were $1.28 per hour and $1.40 per hour, respectively. According to an SF 57, "Application for Federal Employment," submitted and signed by Mr. Flye, his duties consisted of "repairs on steam traps, valves, hot water lines, steam and return lines, rework steam regulator valves, traps, condensation pumps, reinsulated boilers, and steam lines." His supervisor at that time was Capt Bill Smith.

c. On 18 September 1947, he was again reemployed at Brookley where he worked until he retired. On his application for disability retirement, he described his disabilities as arthritis all over his body, heart disease, and hypertension. Although his last day of work was 29 May 1967, his disability retirement was not effective until 17 August 1967. On his last day of work, he was an Electrical Components Quality Control Inspector, W(WB)2870, Grade 11, Step 3, $3.21 per hour. It is noted that while he was apparently in a sick leave status he was promoted with a change in appointing authority to Kelly Air Force Base, Texas. No exposure is indicated during

Figure 810-39. Sample Letter to OWCP Regarding Claimant No Longer Employed.

this 20-year time frame. From his documented work history, it appears that during periods of non-Federal employment (both prior to and after the 1946-1947 period), he may have incurred considerable asbestos exposure when he worked around shipyards, shingles and insulation materials. For example, asbestos exposure while working at shipyards would normally be expected to be much greater than that of an Air Force installation where exposure would probably be only 10 to 15 minutes a day. Possible periods of considerable non-Federal exposure are:

(1) From 1938 - 1939, when he was employed by the South Mississippi Steamship Co., Jacksonville, Florida, as a Laborer painting and cleaning ships.

(2) From October 1939 to August 1940, when employed at the Atlas Roofing Co., Birmingham, Alabama, as a Shingle Stacker stacking shingles on pallets to be placed in dryer kilns.

(3) From September 1940 to April 1942 and from June 1947 to September 1947, when employed at the Georgia Dry Dock and Ship Co. as a Pipefitter, where he did new and repair work on all kinds of steam ships. (The latter period immediately followed the alleged Air Force exposure.)

(4) From 1956 to 1958, when he worked part-time (10 hours a week) as a commercial electrician wiring houses, installing electric hot water heaters, water pumps, and electrical components. (This is also after the 1946-1947 period and it appears that this type of work could easily result in asbestos exposure from insulation materials.)

The evidence presented in the medical record does not document any parenchymal pulmonary fibrosis as a result of asbestos exposure. There is no evidence of any pulmonary or general medical disability as a result of his past asbestos exposure. Calcified pleural placques as a result of asbestos exposure are considered "benign." They cause no pulmonary disability and are not a precursor to future pulmonary disease. Since pleural calcifications can be caused by conditions other than asbestosis and Dr Jones' report (1) does not provide reasoned medical opinion to support causal relationship, or (2) a diagnosis of asbestosis (as claimed by Mr. Flye), we request that Mr. Flye's x-rays be sent to us for review and interpretation by one of our radiologists with expertise in asbestos-related pulmonary disease.

The x-rays can be sent to the undersigned or to John Williams, M.D. Chief of Occupational Medicine Services, HQ AFMC/SGPO, Wright-Patterson AFB, Ohio, 45433-5001.

Prior to adjudicating Mr. Flye's claim, it is recommended that he be required to complete Forms CA 935 and 936 so that Social Security records can be obtained to ascertain any other periods and places of employment following the alleged Federal exposure. Furthermore, should the claim be approved, we believe he should be entitled to medical benefits only as the claimed condition will not add to his already totally disabled status. Copies of pertinent documentation contained in his OPF are enclosed in the indexed evidence packet. It is interesting to note that if

Figure 810-39 Continued. Sample Letter to OWCP Regarding Claimant No Longer Employed.

there were other records in the OPF which would have been helpful, they were sent to Mr. Flye on 13 November 1993. The chargeback code for this claim would be 3721 UL (MOAMA Old).

We would appreciate your keeping us advised of the status and the final decision. If further assistance is needed, please contact me at 614-522-0001 or Dr. Williams at 614-522-0002.

Sincerely,

MELVIN A. BROWN
Injury Compensation Program
Administrator

2 Encl
1. CA-2
2. Evidence File

Figure 810-39 Continued. Sample Letter to OWCP Regarding Claimant No Longer Employed.